SHELBY COUNTY GOVERNMENT
FLEXIBLE BENEFITS PLAN ENROLLMENT FORM

Name: _____

Social Security #: _____

Department: _____

The purpose of this form is to enroll your benefits plan coverage under the Shelby County Government Flexible Benefits Plan ("FLEX PLAN"). This form alone CANNOT be used to enroll in any benefit plan.

This form merely indicates what coverage you have otherwise enrolled in which is subject to the Shelby County Government Flexible Benefits Plan. You must indicate below which of the following coverages will be in effect for your participation in the Flexible Benefit Plan.

The "employee cost" of coverage under any benefit plan shall be provided in writing to you. That written cost information is considered a part of this form.

BASIC BENEFITS

Shelby County Health Insurance Benefits Program

I have enrolled for coverage under the Shelby County Health Insurance Benefits program, to the extent of coverage shown below.

I will be covered under either the United Healthcare Plan (PPO) or CIGNA Healthcare plan (POS).

( ) United Healthcare Plan (PPO)

  Single Family

( ) CIGNA Healthcare Plan (POS)

  Single Family

OVER---------

I agree that an amount equal to the "employee cost" for all health insurance benefit programs in which I enroll above will be redirected out of my wages on a pre-tax basis to pay for my coverage. My W-2 statement will show my wages after this redirection. This amount will be redirected from my wages per pay period. I understand that my enrollment in Shelby County Benefit Programs and related payroll redirection is IRREVOCABLE and may not be changed until the next enrollment period, except in the case of a change in family status, as provided under Article 3 of the plan.

The Shelby County **Group Life Insurance Plan** is mandatory for all full-time (permanent and durational) employees. If you are a part-time employee, life insurance and health coverage are optional. Employee contributions for the Shelby County Group Life Insurance Plan for the first $50,000 of coverage will be redirected from wages on a pre-tax basis. Coverage amount above $50,000 will be paid for by payroll deduction on an after-tax basis.

I understand that:

IN THE EVENT I DO NOT COMPLETE AND FILE THIS ENROLLMENT FORM, I WILL BE DEEMED TO HAVE SO COMPLETED AND FILED IT IN CONFORMITY WITH MY ACTUAL BENEFIT PLAN COVERAGE EFFECTIVE FOR THE PREVIOUS ENROLLMENT PERIOD.

This form shall be deemed to continue in effect until it is revoked pursuant to the terms of the plan. New Enrollment in any plan may require proof of insurability.

If present Shelby County policy prohibits my coverage under any of these benefit plans, the completion of this enrollment form does not waive that prohibition.

In the event I do not want the tax advantage of participation in this flexible benefits plan, I understand that I must contact the Employee Benefits Manager by a separate written communication to opt not to participate in the flexible benefits plan.

I acknowledge that I have been provided a written explanation of the Shelby County Government Flexible Benefits Plan.

Check applicable box for employee status:

( ) Full-time employee ( ) Part-time employee
(If checked, identify life and health care election)

_____ I elect life coverage

_____ I elect health coverage
(Indicate plan on reverse side)

_____ _____

(Flex) Date **Employee's Signature**